

Houston EMA Intimate Partner Violence Protocol

Introduction:

Nearly one-third of American women will experience intimate partner violence (IPV). Physical, sexual and emotional violence within male same-sex relationships is estimated to impact up to 46% of gay men¹. Immigrant women often suffer higher rates of battering than U.S. citizens because they may come from cultures that accept domestic violence or because they have less access to legal and social services than U.S. citizens.² Studies show substance abuse and high-risk alcohol use are more prevalent among women who experience IPV compared to women who have not experienced IPV, women with a history of IPV are at high risk for engaging in sexual activity that can lead to unintended health outcomes, and that IPV has a detrimental effect on HIV control and treatment. Given these statistics, it is very likely that patients receiving medical treatment in the Ryan White system of care are affected by intimate partner violence. Houston EMA Ryan White (RW) providers play an important role in the health of our HIV+ community, as well as the community at large. Therefore we must place identification and intervention of this issue in the foremost part of our mind and take it as a very serious concern.

Purpose:

The purpose of this protocol is to aid in identification, treatment and intervention of patient intimate partner violence in a clinical setting. Medical professionals are often the first or the only professionals to come into contact with individuals in abusive situations. Clinic staff has a unique responsibility and opportunity to intervene.

In 2011 the Institute of Medicine (IOM) released recommendations for preventive health care services for women, which included screening and counseling for interpersonal and domestic violence. Per the IOM recommendation, "screening and counseling involve elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems."³ To ensure effective implementation, these standards require educational programs for staff in domestic violence. This protocol is intended to assist medical professionals in complying with intimate partner violence screening standards and thus improving service to our patients.

Traditionally health care practitioners are not instructed in such intervention or in how to respond appropriately when domestic violence affects their patient's life. Training for health care providers has proven to be very effective in implementing and improving the quality of health care given to battered patients. Our policies will include procedures for identifying and documenting partner abuse, providing patient information about community resources and educating staff on handling these cases. Although nationally the great majority of victims are female, we understand that a significant portion of our service population may encounter male to male intimate partner violence. Therefore, victims will be referred to a "he/she" for the

¹ Stephenson, R. (July, 2012). *The IPV-GBM Scale: a new scale to measure intimate partner violence among gay and bisexual men*. Unpublished paper presented at The International AIDS Conference, Washington D.C.

² Orloff et al., 1995. "With No Place to Turn: Improving Advocacy for Battered Immigrant Women." *Family Law Quarterly*. 29(2):313.

³ *Clinical Preventive Services for Women Closing the Gaps*, accessed 9/26/12, <http://www.iom.edu/~media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/Preventive%20Services%20Women%202011%20Report%20Brief.pdf>

purposes of this document. We do also recognize that violence occurs female to male and other in same sex relationships. The same guidelines apply in these cases.

Definition:

Intimate Partner Violence (IPV) describes physical, sexual or psychological harm caused by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

- **Physical violence** is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person.
- **Sexual violence** is divided into three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) abusive sexual contact.
- **Threats of physical or sexual violence** use words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.
- **Psychological/emotional violence** involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do (such as preventing access to medical care or medications), withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. In addition, stalking is often included among the types of IPV. Stalking generally refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property

I. Screening:

IPV and its sequelae are present in numbers to justify routine screening. Early recognition and intervention can significantly reduce the morbidity and mortality that results from violence in the home. An individual may not initially recognize himself/herself as "battered"; therefore the medical professional should routinely ask all clients direct specific questions about abuse.

A. Who to Screen and How Often

1. All adults and adolescents primary care patients aged 14 years and up should be screened at initial visit and at least annually thereafter.
2. Patients who present with clinical findings that may indicate abuse should be screened as indicated:

Alcohol or drug abuse
Injury inconsistent with patients explanation
Repeated use of the ER
Eating disorders
Chronic pain syndromes
Injury during pregnancy
Prior history of trauma
Vague psychosomatic complaints
Multiple injuries in various stages of healing
A partner who will not leave the exam room
Injury to the head, neck, torso, genitals, breast or abdomen
Delay between onset of injury and seeking care
Psychological distress (suicidal, depression, anxiety or sleep disorders)

B. What to Screen

1. Patients should be screened for ongoing IPV (physical, sexual, and psychological).

C. How to Screen

Screening procedures and related personnel will vary based on the clinic structure at each RW adult primary care provider. Below are individual screening procedures for each Houston EMA Ryan White adult primary care agency.

1. Harris Health System - Thomas Street Clinic IPV Screening Procedures

a. Screening Tool

Harris Health System will utilize the Ongoing Abuse Screening tool to screen all patients.

b. Screening Method

Screening will be conducted by the Patient Care Technician (PCT)/CCS through patient interview at review of systems in patient exam room at every visit.

c. Positive Screenings

- PCT will inform charge nurse of all positive screens.
- Charge nurse will conduct a danger assessment for all positive screens.
- Charge nurse will refer all positive screens to Crisis Intervention Medical Case Manager (MCM) with danger assessment findings for immediate safety planning and referrals.
- Charge nurse will inform the primary care provider (PCP) of all positive screens and danger assessment results.
- Crisis Intervention Medical Case Manager will review danger assessment and with patient, discuss safety planning, referrals and follow-up at the positive screening visit.
- Positive screening result will be added to the patient problem list by the PCP.

2. Houston Area Community Services Screening Procedures

a. Screening Tool

Houston Area Community Services will utilize the Ongoing Abuse Screening tool to screen all patients.

b. Screening Method

Screening will be conducted by self-report annually through OAS tool inclusion on patient health history form. Screening results are reviewed by the eligibility specialist during the patient eligibility appointment.

c. Positive Screenings

Eligibility specialist will immediately send notification of a positive screen to the PCP and the PCP's team medical case manager through SpringCharts. The positive screening result will be added to the patient problem list by the PCP. Positive screens are referred to PCP team medical case manager at time of eligibility specialist review for danger assessment, safety planning, and referral.

3. Legacy Community Health Services Screening Procedures

a. Screening Tool

Legacy Community Health Services will utilize the Ongoing Abuse Screening tool to screen all patients.

b. Screening Method

Screening will be conducted by self-report annually through OAS tool inclusion on patient health history form. Screening results are reviewed by clinic medical assistant in patient exam room. PCP will also review screening results at office visit and validate screen with signature.

c. Positive Screenings

Positive screening result will be added to the patient problem list by the PCP. Positive screens are referred to PCP team medical case manager at time of review for danger assessment, safety planning, and referral.

4. St. Hope Foundation Screening Procedures

a. Screening Tool

St. Hope Foundation will utilize the Universal Violence Prevention Screening Protocol to screen all patients.

b. Screening Method

Screening will be conducted by Service Linkage Workers and Medical Case Managers through patient interview at CPCDMS eligibility update twice annually (every 6 months).

c. Positive Screenings

Positive screens are immediately referred to on-duty clinical case manager at time of review for danger assessment, safety planning, and referral. Clinical case manager will document PCP notification of positive screen in client record and confirm that positive IPV screen has been added to patient problem list prior to next primary care office visit. If positive IPV screen is conducted on the same day of primary care office visit, the PCP will be notified and screening information added to problem list immediately (same day).

II. Danger Assessment, Safety Plan, and Referral

A. Danger Assessment

All patients with a positive IPV screen will receive a danger assessment using the RWGA danger assessment tool (see attachment 2). Danger assessments will be conducted and assessed by responsible agency personnel as outlined in section IC, 1-4c.

The following factors should be considered when determining the lethality of the patient's current environment.⁴

- **Perpetrator's access to victim**
- **Pattern of the perpetrator's abuse**
 - frequency/severity of abuse in current, concurrent, and past relationships
 - use and presence of weapons
 - threats to kill
 - hostage taking
- **Perpetrator's state of mind**
 - obsession with victim
 - increased risk-taking by perpetrator
 - ignoring consequences
 - depression
 - desperation
- **Individual factors that reduce behavioral controls of either perpetrator or victim**
 - substance abuse
 - certain medications
 - psychosis
 - brain damage, etc.
- **Situational factors**
 - separation violence
 - increased autonomy of victim
 - presence of other stresses

Outcomes of danger assessment should be documented and used as a guide in the development of the patient safety plan.

B. Safety Plan

All patients with a positive IPV screen will receive a safety plan which is developed based on outcomes danger assessment. This initial safety plan should outline precautions suitable for the patient's immediate needs following the screening visit. Safety plans should consider patient priorities and comfort level with the following options:⁵

- Leaving or staying somewhere else temporarily
- Addressing reoccurring violence if patient returns to abuser
- Addressing reoccurring violence if the abuser is removed (i.e. through arrest, restraining order, etc.)

Complexity of individual safety plans will vary widely based on the current situation of each patient. It is appropriate that patients requiring long-term, complex, and/or detailed safety planning be referred to internal medical case management services and/or domestic violence service organizations for further assistance. However, all positive IPV screened patients must have an initial safety plan in conjunction with their danger assessment documented in their medical record. If appropriate, patient should also be given safety plan as a resource (see attachment 3).

C. Referrals

All patients with a positive IPV screen will be referred to agency's medical or clinical case management for follow-up and additional assistance. Additional referral to shelters, IPV

⁴ Ganley, Anne L., Ph.D. "Assessment." *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers*. By Carole Warshaw, M.D. 2nd ed. N.p.: Family Violence Prevention Fund, n.d. 70. Print.

⁵ Ganley, Anne L., Ph.D. "Intervention." *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers*. By Carole Warshaw, M.D. 2nd ed. N.p.: Family Violence Prevention Fund, n.d. 73-75. Print.

counseling organizations and/or other IPV related resources (see attachment 4) should be made based on the patient's individual need as a component of the patient safety plan.

All organizations listed as a Houston EMA IPV Referral Organization (attachment 4) have contact information listed in the Blue Book, except Casa Juan Diego. The Blue Book can be given to all patients as a referral resource that will not denote to perpetrators specific assistance with IPV.

Forensic Nurse Referral

The Houston EMA has two options for forensic nursing services for patients with visible injuries and/or reports a recent (within 96 hours) sexual assault. Forensic nurses from Harris Health System Forensic Nursing Services are available to collect and photograph evidence of intimate partner violence at hospitals and clinics within the Harris Health System, this includes Thomas Street clinic. Patients with visible injuries or who report a recent sexual assault should be asked if they will consent to have evidence collected by Harris County forensic nurses. If the patient agrees, Harris Health System forensic nurses can be contacted through the paging operator at (713)873-2010. A nurse will arrive at any Harris Health System clinic within approximately 90 minutes.

For forensic nurse referrals at clinics outside of Harris Health System, Memorial Hermann maintains a forensic nurse response team and mobile unit. The mobile unit services hospitals throughout the Memorial Hermann system and is able to support seven area counties. Patients wishing referral to this service should present at the nearest Memorial Hermann emergency room.

Patients with visible injuries or who report a recent sexual assault that decline consent for the collection of photographic evidence, should have injuries documented on the body maps on the danger assessment and documentation form. Injury documentation should also include a description of the injuries (coloration, size, etc.), stated or suspected cause of injury, action taken by clinician.

III. Case Management Intervention

All patients with a positive IPV screen will be referred to agency's medical or clinical case management for follow-up and additional assistance. Case managers should review the danger assessment for information on safety in contacting the patient regarding IPV prior to any IPV follow-up.

IPV case management referrals should be managed similarly to other patient needs. Re-assessment, referral, follow-up and service planning should be tailored to the client's needs and in accordance to current case management standards of care.

IV. Continuity of Care

To ensure continuity of care, PCPs should review previous danger assessments at subsequent office visits. Inquiry should be made to changes in the IPV situation. If any escalation is identified, re-assessment should be initiated through procedures outlined in section IC, 1-4c.

V. Documentation

All primary care patients must have at minimum, one completed IPV screen documented in their medical record annually. Screening documentation must include questions and patient responses as indicated on agency designated IPV screening tool.

For patients with a positive IPV screen, medical record must include documentation of a completed RWGA danger assessment (see attachment 2) and safety plan (see attachment 3). All patients with a positive IPV screen should also be referred to RW medical or clinical case management services. The patient medical record should include documentation of case management referral and case management client contact (or attempts) related to positive IPV screen.

VI. Mandatory Reporting:

- A.** Texas law requires any person who believes that a child (<18 years old) or person 65 years or older or an adult with disabilities is being abused, neglected, or exploited to report the circumstances to the Texas Department of Family and Protective Services (DFPS) Abuse Hotline. A person making a report is immune from civil or criminal liability, and the name of the person making the report is kept confidential. Any person who suspects abuse and does not report it can be held liable for a Class-A misdemeanor. A professional must report suspected abuse or neglect of a child within 48 hours of suspecting the child has been or may be abused or neglected (Texas Family Code 261.101, Human Resources Code 48.051).

- Types of Abuse/Neglect/Exploitation

What is Abuse?

- Abuse is mental, emotional, physical, or sexual injury to a child or person 65 years or older or an adult with disabilities, or failure to prevent such injury.

What is Neglect?

- Neglect of a child includes (1) failure to provide a child with food, clothing, shelter and/or medical care; and/or (2) leaving a child in a situation where the child is at risk of harm.
- Neglect of a person 65 years or older or an adult with disabilities results in starvation, dehydration, over- or under-medication, unsanitary living conditions, and lack of heat, running water, electricity, medical care, and personal hygiene.

What is Exploitation?

- Exploitation is misusing the resources of a person 65 years or older or an adult with disabilities for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

- There are two options for reporting abuse, neglect and exploitation to the Texas Department of Family and Protective Services.
 - By Phone: Call the Abuse Hotline, 24 hours a day, 7 days a week, toll-free 1-800-252-5400
 - By Secure Internet Website: From your internet browser, go to <https://www.txabusehotline.org>.

- B.** Injuries resulting from gunshot wounds must immediately be reported to law enforcement (Texas Health & Safety Code 161.041).

VII. Training

Mandatory training is required annually and during orientation for all Ryan White Part A funded, primary care co-located, case management staff (SLW, MCM, CCM).

Annual and orientation IPV training must include:

- Domestic Violence Basics
 - Survivors' perspectives
 - Dynamics of victimization and perpetration
 - Cultural competency
 - Physical and mental health consequences of IPV on victims and children exposed
 - Referral Resources
- IPV Screening Skills
 - How to assess, intervene, support and document appropriately
 - Interactive role playing and modeling of assessment and response techniques
- Boundary setting and self-care

RWGA will host two trainings annually covering the above training topics.

Additionally, all personnel with IPV screening, safety planning, and/or intervention responsibilities per their agency's IPV protocol must receive training annually and during orientation. All IPV training eligible staff must receive an annual review of their agency's IPV protocol.

Attachments:

1. RWGA Approved Screening Tools
 - a. *Ongoing Abuse Screening Tool*
 - b. *Universal Violence Prevention Protocol*
2. RWGA Approved Danger Assessment
3. RWGA Approved Safety Plan
4. Houston EMA IPV Referral Organizations
5. Agency IPV Protocol